Patient Safety Program Approach – HCQCC, May 2012

Goal

By January 2014 all settings in which patient care is delivered shall establish a Patient Safety Program.

Outline of Voluntary Program Elements (Defined in the resource guide):

- Leadership in the setting
- Identify a patient safety point of contact at the site (not necessary to hire for this position)
- Continual process improvement
- Regular review of events and concerns (monthly or quarterly staff meetings):
 - Analysis of event(s) that occurred and plans for corrective action(s)
 - o Identify risks or potential problems before they occur and take correct action(s)
 - o Review risks and possible risks in transitions of care
- Input from patients and families

Implementation

- Share with state agencies that interact with health care organizations
- Partner with professional organizations and associations who will work with their members, providing education, sharing best practices, and assessing implementation
- Provide as a general resource this brief guide to the professional organizations and associations to share with their members. Encourage professional organizations and associations to add strategies and resources for their specific health care setting.
- Develop a reporting survey with professional organizations and associations that will be
 given to each member for voluntary completion, to be shared in aggregate with the
 HCQCC through the professional organizations and associations at the end of the pilot
 period, and again annually. Template will include questions about the important and
 sustainable elements of a patients safety program

Year 1 (2012): Engagement

Year 2 (2013): Progress in settings with feedback from professional organizations and associations to the HCOCC and survey development

Year 3 (2014): Data collection and Public Engagement

- Data collection by professional organizations and associations of their members' patient safety initiatives to be shared in aggregate to the HCQCC initially. Future reports from each association will be considered for public sharing.
- Outreach to the public to explain that healthcare settings have patient safety programs. Ask for the patient safety coordinator at your facility if you have suggestions or want more information

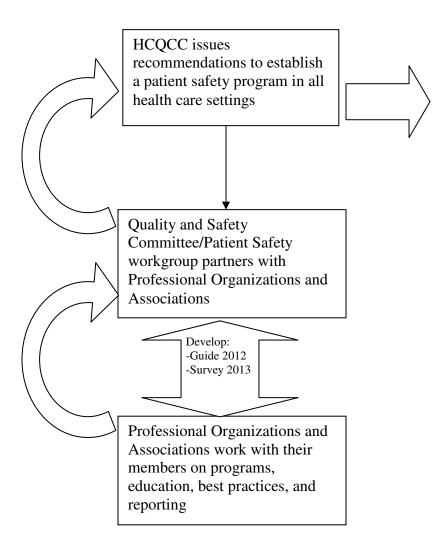
Timeline: 2011 - 2013

Month	Task
Jan 2011 –	Develop initial guide "Guideline for Patient Safety Program in all
April 2012	Healthcare Settings"
	Develop rollout process
	Define list of state agencies for outreach
	Define full list of professional organizations and associations
May 16 2012	Quality and Safety Committee complete draft document, present for
	HCQCC approval
	Present rollout process for HCQCC comment
May 2012 –	Post document on HCQCC website
December 2012	Quality and Safety Committee engage Professional Organizations and
	Associations through a series of small meetings; get input for strategy
	Develop cover letter for EOHHS Secretary; with professional
	associations, develop draft cover letter language for endorsement
	• Quality and Safety Committee collects comments, additional resources, providers update to HCQCC
	Professional Organizations and Associations begin outreach to engage
	their memberships
January 2013-	Professional organizations continue to offer education, feedback and
May 2013	tools to their members on best practices and lessons learned
	Professional organizations and Quality and Safety Committee, with
	HCQCC, develop a survey tool to be used in fall of 2013
June 2013-	Quality and Safety Committee outreach to professional associations to
December 2013	conduct survey

2014 and Beyond

Month	Task
January 2014 – March 2014	Professional organizations report back best practices and lessons learned in aggregate to Committee.
	Results reviewed by professional organizations and committee and consideration be given to having the HCQCC post progress on its administrative website
January 2014 - December 2014	 Professional organizations continue to offer education, feedback and tools to their members on best practices and lessons learned Outreach to patients/consumers about patient safety programs in all settings
	Data collection using surveys in fall 2014
January 2015	Reporting in aggregate by the Professional organizations and associations to the HCQCC on progress in settings based on Year 1 of the survey data
March 2015	Review of results and consideration by the committee and professional organizations regarding HCQCC posting progress on its administrative website

Patient Safety Program Process



Jan 2014: HCQCC posts lessons learn and best practices from Professional Organizations and Associations Administrative website

Jan 2015: HCQCC posts year 1 of survey data from the Professional Organizations and Associations as aggregate reports from their members